Choice Therapy

Choice Therapy Pediatric Patient Registration

Date: Patient Name:

DOB: Parent / Caregiver Name:

Age: Grade: Sex: ☐ Male ☐ Female ☐ Prefer not to say

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If Yes, what language?

Does the child speak this language? ☐ Yes ☐ No Does child understand this language? ☐ Yes ☐ No

Number of children in family and ages:

Who lives in home with patient / caregiver/family status (ie married, coparent, single, split custody)?

How did you hear about us? ☐ Friend/Family ☐ Website ☐ Facebook ☐ Google ☐ Prior Patient

☐ Doctor's Order Other:

Physician/Pediatrician: Date of Last Doctor Visit:

Current Medical Diagnoses:

Reason for Referral:

PARENT / CAREGIVER HISTORY OF CONCERNS

What would you like to be easier for your child and helpful for home and daily life?

What is your primary concern at this time?

What are your child's strengths?

Any concerns with sibling interactions? ☐ Yes ☐ No If yes, please describe

Has your child received previous therapy evaluation and/or treatment? ☐ Yes ☐ No

If yes: ☐ PT ☐ OT ☐ Speech When? Where?

For how long? Please specify areas that were addressed during previous treatment

When did you first notice your child having difficulty?

Is the child receiving any other outside services? ☐ Counseling ☐ Psychology ☐ Chiropracter ☐ Behaviorist ☐ Autism Specialist ☐ Early Intervention Other:

PREGNANCY AND BIRTH

Child was born: ☐ Full Term ☐ Premature If premature, how many weeks?

Delivery: ☐ Vaginal ☐ With Forcepts ☐ C-Section Complications?

Was your child placed in the neonatal intensive care unit? ☐ Yes ☐ No How long?

Please describe any other medical problems or complications at birth

MEDICAL HISTORY

Allergies? ☐ Yes ☐ No If yes, please describe

Hospitalizations? ☐ Yes ☐ No If yes, please describe

Surgeries? ☐ Yes ☐ No If yes, please describe

Recent vision exam? ☐ Yes ☐ No Date Results

Dr. Glasses: ☐ Yes ☐ No

Recent hearing exam? ☐ Yes ☐ No Date Results

PE Tubes placed in the middle ear? ☐ Yes ☐ No If yes, when?

Current medication(s) including supplements and over the counter medications:

Current physical limitations:

Are there any precautions or activities child should not participate in?

Special equipment or assistive technology used:

DENTAL /ORAL HISTORY

Has your child been seen by a dentist? ☐ Yes ☐ No If yes, how often? Date of last visit Any difficulties at the dentist? ☐ Yes ☐ No

If yes, please describe:

Does your child choke or have difficulty swallowing food or liquid? ☐ Yes ☐ No If yes, please describe

Does your child put toys or objects in their mouth? ☐ Yes ☐ No

Does your child brush his/her teeth? ☐ Yes ☐ No

Does he/she allow you to brush his/her teeth? ☐ Yes ☐ No

NUTRITION, FEEDING, CONTINENCE & SLEEP

Has your child had any unusual feeding / dietary problems? ☐ Yes ☐ No If yes, please specify?

Do they choke/cough while eating? ☐ Yes ☐ No Any food allergies? ☐ Yes ☐ No

Sleep: ____ Hours per night ____ Naps (#) ____ Nap Length (hours)

Any difficulty with sleep

If your child is age 5 or older, does he/she: ☐ wet during the day ☐ wet at night

☐ experience constipation ☐ not a concern

DEVELOPMENTAL HISTORY – COMPLETE FOR CHILDREN AGES 0-5

Please indicate at what approximate age your child achieved the following milestones:
*Leave blank those which your child has not yet achieved.

____ Rolled over	____ Drank from a cup	____ Spoke in short sentences
____ Sat alone	____ Drank from a straw	____ Used a spoon
____ Crawled	____ Followed 1-step direction	____ Toilet trained
____ Pulled to stand	____ Followed 2-step direction	____ Dressed self
____ Cooed (vowel sounds)	____ Pointed to objects	____ Walked alone
____ Babbled (consonants heard)	____ Stood alone	____ Identified family members
____ Said first word	____ Used two words together	

EDUCATIONAL INFORMATION

School/Educational program currently attending:

Present grade level: Special services received in school:

Does your child have a current IEP? ☐ Yes ☐ No

Community participation/extracurricular activities:

Interests:

Comments/Additional information:

COMMUNICATION / SOCIAL-EMOTIONAL DEVELOPMENT

How does your child communicate? ☐ pointing/gestures ☐ sounds ☐ words ☐ sentenses ☐ phrases

Does your child understand what you say? ☐ Yes ☐ No

Does child answer "wh" questions appropriately? ☐ Yes ☐ No

Does your child interact well with others? ☐ Yes ☐ No

Does child answer yes/no questions appropriately? ☐ Yes ☐ No

Do your family members understand your child? ☐ Yes ☐ No

Does your child have any trouble making friends? ☐ Yes ☐ No

Does your child show appropriate eye contact? ☐ Yes ☐ No

Does your child demonstrate safety awareness? ☐ Yes ☐ No

Does your child follow 1-2 step multi-step directions? ☐ Yes ☐ No

Does your child transition easily? ☐ Yes ☐ No

Does your child have difficulty calming himself/herself when upset? ☐ Yes ☐ No

Does your child become upset and/or frustrated when unable to communicate wants, needs, and thoughts?
☐ Yes ☐ No

Are you able to identify certain triggers for your child?

Fears/coping behaviors:

Additional comments:

PLAY SKILLS

Check areas of difficulty: ☐ plays well with siblings ☐ has friends ☐ has play dates

☐ difficulty with winning/losing ☐ attention span other

BEHAVIOR

Please check any of the following that apply:

☐ Cries often	☐ Dislikes hair brushing	☐ Rocks self
☐ Frequent temper tantrums	☐ Dislikes tooth brushing	☐ Sensitive to light or sound
☐ Anxious	☐ Avoids touch from others	☐ Aggressive (biting, hitting)
☐ Trouble following directions	☐ Dislikes playground equipment	☐ Poor attention span
☐ Trouble with changes in routine	☐ Seems to be "on the go"	☐ Mouths objects
☐ Clumsy, tripping, falling	☐ Weak muscles	☐ Picky eater

☐ Dislikes certain clothing textures Other:

What makes the symptoms better?

What makes the symptoms worse?

PARENT / CAREGIVER CONCERNS

Is there anything else you would like us to know about your child that has not been addressed in the previous questions?

If child is being evaluated for OT or PT (occupational or physical therapy)…….
Please check any of the following performance skill areas that you child is having difficulty with.

VISUAL PERCEPTION

☐ Inattention and distractibility to written and/or reading tasks.

☐ Difficulty writing, reversal of letters such as b for d or p for q

☐ Difficulty copying from a blackboard or a whiteboard

☐ Difficulty with puzzle pieces – gives up

SELF CARE

☐ Dressing: clothes or shoes on backwards, shoes on wrong feet

☐ Food pushed off plate, messy eating

☐ Needs assistance with toileting (ie clothing, wiping)

SOCIAL SKILLS

☐ Withdrawal from social situations

☐ Poor eye contact Lack of confidence in oneself

☐ Poor body language

☐ Making friends / getting along with others

FINE MOTOR

☐ Difficulty holding pencil or utensil / awkward grasp

☐ Unable to complete mazes, dot-to-dots, etc.

☐ Poor scissor skills

☐ Difficulty holding or avoids small objects, pencils or scissors

GROSS MOTOR (MOTOR AND PRAXIS SKILLS)

☐ Flinching or other responses when catching a ball

☐ Fear response to gross motor activities

☐ No motivation or avoids gross motor activities Unable to hop, skip, jump, run, etc.

☐ Difficulty maintaining balance while walking, trips or falls often

☐ Difficulty coordinating both sides of body

☐ Problems planning and carrying out new actions, difficulty forming an idea or developing new motor skills

SELF-REGULATION

- ☐ Responding to the feelings of others by acknowledgment or showing support
- ☐ Controlling anger toward others and reducing aggressive acts
- ☐ Recovering from a hurt or disappointment without lashing out at others
- ☐ Displaying emotions that are appropriate for the situation
- ☐ Persisting in task despite frustrations
- ☐ Difficulty calming down
- ☐ Over-responsive to sensation, fight or flight response to sensation (aka sensory defensiveness)
- ☐ Under-responsive to sensation, seem to have a continuous desire for sensory stimulation